



Health  
Information  
**2008-2009**

Washington School  
for the Deaf

# Student Information

Student Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Allergies \_\_\_\_\_ Date of Last Tetanus Shot \_\_\_\_\_

## Medical Care

I authorize the Washington School for the Deaf medical staff to provide medical treatment to my student and administer anesthetic by qualified personnel if it becomes necessary. Washington School for the Deaf staff has the right to give first aid treatment to any student, and to seek and retain medical emergency or rescue services to treat, transport and/or hospitalize a student.

I am responsible for providing payment or medical insurance coverage for my student including medical expenses, evacuation and/or emergency transportation charges. Washington School for the Deaf does not provide medical insurance coverage for students and will not held responsible for medical expenses under any circumstance.

Parent/Guardian Signature \_\_\_\_\_

## Ear Health

☐ I prefer to clean my student's ears myself.

☐ I give permission for the WSD nurses to instill medications and/or water in to my student's ears to clean them as needed.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

## Heart History

Long QT Syndrome, LQTS, is a hereditary abnormality of the heart's electrical system that can cause cardiac arrest and sudden death. LQTS is very rare and occurs slightly more often in people who were born deaf than to those born hearing.

Have any of your student's family members had a sudden unexplained death? ☐ No ☐ Yes (If yes is checked, please respond below.)

Who? \_\_\_\_\_

When? \_\_\_\_\_

Has your student ever fainted? ☐ No ☐ Yes (if checked please respond below)

When? \_\_\_\_\_

How often? \_\_\_\_\_

Your student should be screened for LQTS if:

☐ A family member had a sudden unexplained death, and/or

☐ Your student has ever experienced fainting spells.

Has your child ever been screened for LQTS? ☐ No ☐ Yes (if checked please respond below)

Who did the evaluation? \_\_\_\_\_ What were the results? \_\_\_\_\_

I understand that if my student is at risk for LQTS as explained above, it is my responsibility to have him/her screened by my family doctor.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

## Insurance Information

Name & Address of Insurance Company

Policy & Group Numbers/Medicare/Union and Local

My Insurance is through

\_\_\_ Employment \_\_\_ Private

Name & Address of Insurance Company

Policy & Group Numbers/Medicare/Union and Local

# Student Health Record

Student Name \_\_\_\_\_

Hearing Loss History (cause of hearing loss): \_\_\_\_\_

Age of onset: \_\_\_\_\_ Age of diagnosis \_\_\_\_\_

Other family members with hearing loss: \_\_\_\_ Yes \_\_\_\_ No Who: \_\_\_\_\_

Dear Parent:

Please describe your child's health problems on the form below. It is important that you keep the school informed of any changes in health or medication which would affect your child's performance. If your child needs to take medication at school, please notify the school nurse.

☐ The health condition that I have described below is of sufficient concern that I would like to consult with the school nurse, I therefore agree to contact the school nurse at (360) 696-6525 ext. 4333 or (800) 613-4228 ext. 4333.

HEALTH HISTORY	
ASTHMA	Type: _____ Special Needs: _____
BLOOD DISEASE Anemia, Hemophilia, etc.	Type: _____ Special Needs: _____
CARDIAC	Type: _____ Special Needs: _____
DIABETES	Medication: _____ Special Needs: _____
SEVERE FOOD ALLERGY	Type: _____ Special Needs: _____
DIGESTIVE DISORDER Food Intolerance, etc.	Type: _____ Special Needs: _____
HEARING IMPAIRMENT OR COMPLETE LOSS	Describe: _____ Special Needs: _____
INSECT STING ALLERGY	Type: _____ Describe reaction: _____
MALIGNANCY	Type: _____ Special Needs: _____
NEUROLOGICAL PROBLEM Hydrocephalus, Cerebral Palsy	Type: _____ Special Needs: _____
ORTHOPEDIC PROBLEM Arthritis, Muscular Dystrophy, etc.	Type: _____ Surgeries: _____ Limitations: _____
RESPIRATORY PROBLEM Cystic Fibrosis, etc.	Severity: _____ Medication: _____ Special Needs: _____
SEIZURE DISORDER Epilepsy, etc.	Type: _____ Medication: _____ Special Needs: _____
URINARY/KIDNEY DISORDER Nephritis	Type: _____ Special Needs: _____
VISION IMPAIRMENT OR COMPLETE LOSS	Describe: _____ Special Needs: _____
DRUG ALLERGY	Medication: _____ Special Needs: _____
SERIOUS ILLNESSES/INJURIES	Describe: _____ Special Needs: _____
SKIN PROBLEMS Eczema, etc.	Describe: _____ Special Needs: _____
VISION PROBLEMS	Glasses: _____ Contact Lenses: _____
OTHER HEALTH PROBLEMS	Describe: _____ Special Needs: _____

☐ *None of the above*

☐ **CHECK HERE IF ANY OF THE ABOVE HEALTH CONDITIONS CONCERNING YOUR CHILD ARE LIFE THREATENING.**

If so, state law requires that medication/treatment orders and a nursing plan be in place before the student attends school (RCW 28A.210 Sec. 1)

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

# Authorization for Administration of Medication at School

Name of Medication \_\_\_\_\_ Dosage \_\_\_\_\_ x \_\_\_\_\_

Time to be given \_\_\_\_\_ [ ] AM [ ] PM      Time to be given \_\_\_\_\_ [ ] AM [ ] PM

Method of Administration [ ] Orally [ ] Other \_\_\_\_\_

Inhalers: Self-administer [ ] Yes [ ] No

Storage instructions: [ ] Room temperature [ ] Refrigeration

Reason for medication \_\_\_\_\_

Possible side effects \_\_\_\_\_

Starting Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I request and authorize the above-named student be administered the above-named medication in accordance with the instructions indicated. I will be monitoring the ongoing health status of this patient.

Physician Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Contact Numbers

(\_\_\_\_) \_\_\_\_\_ office

(\_\_\_\_) \_\_\_\_\_ fax

Physician Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## ***This Portion to be completed by parent/guardian***

I certify that I am the parent, legal guardian or other person in legal control of the above - named student. I have read this form and request and authorize the school to administer the medication. The **medication** is to be furnished by me in the ORIGINAL prescription container.

I understand my signature indicates that the school accepts no liability for adverse reaction when the medication is given in accordance with the physician/dentist.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# ***Authorization for Administration of Over-the Counter Medications***

## **Examples of Over-the-Counter Medications**

**Authorized by the Student Health Center Medical Director**

### **HEALTH COMPLAINT**

### **EXAMPLES OF MEDICATIONS USED**

Acne	Phisoderm cleanser, benzoyl peroxide or cream
Allergies	Benadryl, Chlorpheniramine, Claritan, Benadryl, Sudafed
Athlete's foot	Lotrimin, clotrimazole
Bee sting	Monosodium glutamate, Benadryl Cream
Clean pierced ears	Rubbing alcohol, hydrogen peroxide
Clean wax from ears	Debrox, hydrogen peroxide
Clean wounds	Phisoderm, hydrogen peroxide, Betadine
Colds	Sudafed, Benedryl
Cold sores, chapped lips	Carmex, A&D ointment, Orabase, Oragel, Abreva
Constipation	Docusate sodium, milk of magnesia, glycerin suppositories
Cough	Robitussin DM, Mentholatum, various throat lozenges
Cuts, scrapes, lacerations	Neosporin, Betadine
Diarrhea	Immodium
Eye irritation	Artificial tears, Visine AC, eye wash, Clear Eyes
Ingrown toenail	Outgrow
Irritated skin, bug bites	Aloe gel, Calamine, Cortaid, Benadryl cream, Solarcaine
Lice treatment	Pronto
Minor burns/sunburn	A&D, aloe vera gel, Noxema, Second Skin
Pain, fever, headach	Tylenol, Advil
Sore muscles	Ben gay, Epsom salts
Sore throat	Various throat lozenges, chloroseptic spray
Sore rectum	Preparation H, Desitin
Upset stomach	Gaviscon, Maalox, Dramamine
Warts	Duofilm, Mediplast, Compound W

### ***Authorization for Administration of Over-the Counter Medications***

WSD nurses have permission to give certain over-the-counter medications for the treatment of minor injuries and illnesses (see enclosed list.)

Before giving your student any medications, the nurse checks your student's medical history, allergies, and any other medications your student is taking to make sure there is no conflict. You will always be notified immediately of any serious illness or injury.

☐ I give WSD nurses permission to treat my student as described above.

☐ I prefer that the WSD nurses call me before giving any over-the-counter medications to my student.

Parent/Guardian Signature

Date